IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Gloria FOSTER
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: 1. The Chief Executive of Surrey County Council in relation to paragraphs 5(1) to (4). 2. The Chairman of the Care Quality Commission in relation to paragraph 5(4).
1	**CORONER** Richard Travers HM Senior Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into **Mrs FOSTER's** death was opened on the 12th February 2013 and was resumed on 1st September 2014. It was concluded on 9th July 2014. The cause of death was: 1a. Pulmonary thromboembolism 1b. Deep venous thrombosis. The conclusion was: Mrs Gloria Foster died from natural causes contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** By January 2013 a decision had been taken by the Metropolitan Police and the UK Border Agency to close a care provider by the name of Carefirst 24 ('the Company'). The closure was to be marked by a raid on the Company's offices which was due to take place on the morning of the 15th January 2013. The Company provided care for, amongst others, some thirteen people in Surrey, one of whom was Mrs Foster. Surrey County Council ('the Council') were made aware of the pending closure. By

	Friday 11th January 2013 the Council were aware of all but three of the service users whose care was provided by the Company and set about making alternative care arrangements for them. Following the raid the details of the remaining three service users were made available to the Council. All three of those remaining service users, who included Mrs Foster, were funding their care privately. By 13.00 hours on the 15th January 2013 Mrs Foster's details, including the nature and the frequency of the care provided, namely four times per day, were known to the Banstead and Reigate Locality team, being the team within the Council with responsibility for organising an alternative care package on her behalf. In the event, nothing was done to arrange alternative care. Consequently, Mrs Foster was left on her own, incapable of looking after herself and with no care, for a period of nine days until she was discovered by a District Nurse. She was admitted to Epsom General Hospital very seriously ill and received treatment for a number of different problems including dehydration. Despite that treatment, she died on the 4th February 2013, whilst still at the hospital. The immobility and the dehydration from that nine day period was found to have made a material contribution to the cause of her death. No proper explanation was given by the Council for the failure to arrange suitable alternative care. The Banstead and Reigate Locality Team were under great pressure of work at the time and the Senior Operation Lead from that team, to whom the task of arranging suitable alternative care had been delegated, said that she had been influenced by the fact that Mrs Foster was a 'self-funder'. She went on to say that there is a bit of an assumption that self funders can manage their own care or have help from others, and although she acknowledged that it was wrong, she said that that had played a part in her mind.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters that gave rise to concerns that circumstances creating a risk of other deaths will continue to exist in the future unless action is taken. The **MATTERS OF CONCERN** are as follows. – 1. The need to have a protocol relating to the provision of additional support for operational staff when the need to prioritise work surrounding the closure of a care provider arises. 2. The need for additional specific training to reinforce to staff the apparent dangers of taking a different attitude to the needs of

	3. The need for additional specific training to ensure that there is a clear understanding of the role of Team Leader in relation to the supervision of tasks delegated by them to other members of their team. 4. The need to ensure that when a care provider is closed, all lines of communication with that provider, including telephone and email, are managed so that anyone who uses any one of those lines to make contact with them is immediately informed of the current situation and of where to go to seek advice or help.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Chief Executive of Surrey Council County and the Chairman of the Quality Care Commission have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following Interested Persons in the Inquest and to the Chief Coroner. 1. [redacted] 2. [redacted] 3. Surrey County Council 4. [redacted] 5. [redacted] 6. [redacted]
9	**Signed:** *Richard Travers* **DATED this 10th day of September 2014**